DISTRICT OF COLUMBIA
OFFICE OF ADMINISTRATIVE HEARINGS
825 North Capitol Street, N.E., Suite 4150
Washington, DC 20002-4210

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH Petitioner, v. SIBLEY MEMORIAL HOSPITAL Respondent.	Case No.: DH-I-07-D100327

FINAL ORDER

I: Introduction

By Notice of Infraction dated July 9, 2007, the Government charged Respondent Sibley Memorial Hospital (Sibley Hospital) with failing to adhere to policies on assessment and monitoring resulting in harm to a patient on May 29-30, 2007. D.C. Official Code § 44-509 (g)[1] and 22 DCMR 2100.2(b). The patient died at Sibley Hospital on May 30, 2007. The Government sought a $10,000 fine for an infraction and $10,000 as penalty for a total of $20,000. Sibley Hospital entered a timely plea of deny on July 23, 2007, and a hearing was held on October 12, 2007.

At the close of the Government's case, Sibley Hospital moved for Judgment as a Matter of Law and dismissal of the charges against it. Carmen Johnson, Esquire, Assistant Attorney General, represented the Government. Nicolas S. McConnell, Esquire, and Daniele E. Herndon, Esquire, represented Sibley Hospital. The Government filed a written opposition to Sibley Hospital's motion.

[1] Amended at hearing to § 44-509(f).

Based on the testimony and record as a whole, I make the following findings of act and conclusions of law. Exhibits are listed in the appendix.

II. Findings of Fact

1. A 53 year old woman, "A.L.," presented herself to the Emergency Department (ED) at Sibley Hospital at 10:19 a.m. on May 29, 2007, with chief complaints of abdominal pain/pressure, irregular bowel movements and nausea. Her vital signs were: blood pressure 105/60; pulse 73; and respirations 20. Her pain was located in the right lower quadrant of her abdomen and was assessed as eight on a ten point scale. Petitioner's Exhibit (PX) 1.

2. Patients in an ED are assigned to categories in a system known as triage depending on the severity of one's condition. A.L.'s condition was classified as nonurgent on a scale that includes emergent, urgent, nonurgent and fasttrack.

3. A physician saw A.L. within 30 minutes of triage.

4. A.L. was given medication for pain (Toradol), nausea (Zofran); and constipation (magnesium citrate).

5. After the Toradol dose, A.L reported a decrease in the pressure in her abdomen. An hour later she reported that she was "feeling a little better."

6. At 3:00 p.m., Patient's blood pressure was 108/81; pulse was 88 and respirations 16. At 3:13, after A.L. asked to go home, her discharge was cancelled because she started vomiting.

7. Sibley Hospital admitted A.L. as an inpatient and at 7:10 p.m. assessed her condition as good. PX 10.

8. At 8:00 p.m., A. L's blood pressure was 108/61. At midnight it was 97/53.

9. At 4:00 the next morning, May 30, 2007, A.L. displayed symptoms of shock: Her blood pressure had dropped to 70/30, and her heart rate and respirations had increased. Her skin was cold and clammy. She stated she felt weak and dizzy. She was placed with her head below her heart (Trendelenberg position) and had intravenous fluids administered rapidly. PX 10 at 2. At 7:15 p.m., she was transferred to the intensive care unit with a diagnosis of perforated bowel. PX 10 at 3.

10. Surgeons performed surgery for a perforated bowel.

11. The Government presented expert testimony from two nurse expert witnesses, Sharon Lewis, R.N. and Andrea Wilson, R.N., B.S.N., M.S., whose testimony I credit in part.

12. Ms. Lewis is a Program Manager for the Healthcare Facilities Division of the District of Columbia Department of Health. Ms Wilson is acting supervisor and nurse consultant for the Healthcare Facilities Division. She worked in an emergency department in the early to mid 1980s. She has also worked as a staff nurse and as nurse specialist reviewing hospital records to assess conformity with policies and procedures.

13. In this case Ms. Wilson received a call about A.L.'s unexpected death, and then went to the hospital to investigate by reviewing the medical records, hospital policies, and triage guidelines. She also interviewed witnesses.

A. Policies

14. Sibley Hospital policy requires that "all patients are fully assessed each shift by the RN." PX 18 part 2 at 10. It also provides that unusual or significant events should be documented. PX 18 part 2 at 11.

15. Sibley Hospital policy further requires that changes in diagnosis, patient condition, and response to care trigger the need for reassessment. PX 18 at 4. No evidence was produced as to the degree of change in vital signs that would require a reassessment. Hearing Transcript 210:20-24.

16. Records demonstrate that A.L was reassessed in response to treatment for pain, but not to the extent recommended by Ms. Wilson.

B. Recommendations

17. Sibley Hospital's Triage Assessment Form for the Emergency Department categories of acuity *recommends* that reassessment for emergent urgent cases be every two hours and as needed and for nonurgent cases every two to four hours and as needed. PX 14. Abdominal pain is one of the listed examples of conditions under the urgent, every two hour category; constipation is one example for the nonurgent, every two to four hour category. PX 14.

18. The triage categories of urgent and nonurgent were developed for purposes of emergency screening.

19. Emergency Department Sibley Nursing Documentation Guidelines provide expectations for several aspects of care, including general, triage and pediatrics. Under a category labeled "Evaluation and Management" is the guideline that "Vital

signs are performed and documented a minimum of every 4 hours beyond the initial assessment . . . [and] more frequently if the patient condition warrants." PX 17 at 2.

20. Nurses in the ED work under specified, voluntary "standing orders," which are applicable before the patient is seen by a physician from the triage stage to beside." PX 15, 16.

C. Summary of Expert testimony

According to Ms. Wilson, hospital policies include standing orders and hospital guidelines. Ms. Wilson explained that she needs to review a hospital's policies and procedures when she conducts an investigation because policies provide more detail than a regulation.

Ms. Wilson opined that staff at Sibley violated hospital policy by misclassifying A.L. as nonurgent because abdominal pain placed her in the urgent class. Had she been treated based on abdominal pain, she would have had nothing by mouth and blood pressures readings would have been taken every two hours in different positions (orthostatic readings). Instead, A.L. received two medications by mouth and, although her blood pressure was monitored, orthostatic readings had not been taken and BP was measured only at 10:24 a.m. and 3:00 p.m. when she was in the ED.

Further, Ms. Wilson opined that under Sibley policy, A.T should have been reassessed after she received pain medication. That reassessment should have included palpation of abdomen, listening for bowel sounds, and vital signs. She opined further that A.L. should have been reassessed within one hour of a Toradol dose, but was not

assessed until two hours had elapsed, because hospital policy requires that a response to medications be documented.

Noting that at midnight, A.L. had a notable change in BP –from 108/61 at 8:00 p.m. to 97/53--- but no reassessment of abdomen, Ms. Wilson opined that A.L.'s vital signs should have been taken more frequently because hospital policy specifies that the frequency increases when a patient's condition changes. No monitoring had been conducted for four hours, during which time A.L.'s blood pressure had fallen, with a reading of 70/30 by 4:00 a.m. A.L. then had symptoms of shock.

III. Discussion and Conclusions of Law

1. This case arises under the Civil Infractions Act, D.C. Official Code §§ 2-1801.01-1802.5 and the District of Columbia Municipal Regulations[2], 22 DCMR 2100, which pertains to hospital personnel and operations. The Government has the burden to prove the infraction by a preponderance of the evidence. D.C. Official Code § 2-1802.03(a).

2. Pursuant to 22 DCMR 2100.2(b), hospitals are required to "adopt administrative policies and rules for operation of the hospital." Sibley Hospital met that requirement with the adoption of policies.

3. Based on its allegation that Sibley Hospital departed from its own policies in treating A.L., the Government brought a Notice of Infraction against Sibley under the following statutory provision:

> Any person who commits a violation of any provision of this subchapter, or any rules or regulations promulgated pursuant to

[2] Abbreviated "CDCR" by Respondent and Lexis.

> this subchapter, that results in demonstrable harm to a patient, resident, or client of a facility or agency, shall be subject to a fine for each offense not to exceed $10,000.

D.C. Official Code § 44-509(f)(1).

4. If at the close of the Government's case, the Government fails to present sufficient evidence to meet its burden, Respondent is entitled to Judgment as a matter of Law. See *Hughes v. District of Columbia*, 425 A.2d 1299, 1302 (D.C. 1981); *see also* D.C. Super. Ct. Civ. R. 52 (c); OAH Rule 2824.1; 1 DCMR 2824.1.

5. When the subject matter is beyond the ken of a layperson, expert testimony is necessary. *Hughes*, 425 A.2d at 1303; *District of Columbia v. Peters*, 527 A.2d 1269, 1273 (D.C. 1987). Although suffering third degree burns after being placed in a hot bath was within the ken of a layperson, *see District of Columbia Dep't of Health v. D. C. Health Care, Inc.,* 2005 D.C. Off. Adj. Hear. LEXIS 91 (Oct. 11, 2005), understanding the cause of a patient's progression to a state of shock is a complex medical matter requiring expert medical testimony.

6. The Government bears the burden of proving that Sibley: a) violated a hospital policy, rule or regulation; that b) resulted in demonstrable harm to A.L.

A. Hospital Policies

7. First, the Government argues that Sibley Hospital violated its own policy by failing to categorize A.L as urgent in the ED, which it argues would have resulted in more frequent monitoring. The triage guidelines on which the Government relies identifies abdominal pain as one example of the urgent level of acuity. At this level, reassessment is recommended every two hours and as needed. Instead, A.L was

placed in the nonurgent acuity level, with a recommended reassessment every two to four hours.

8. Triage categories and hospital guidelines present recommendations, require judgments, and are voluntary. PX 16. A nurse may use her or his judgment and implement all, part or none of a guideline.

9. Because of the discretion allowed for placement in the various acuity levels and because the frequency of reassessment is a recommendation for each level, I cannot find that the acuity levels were "policies." Accordingly, no policy violation occurred when A.L. was assigned to the non-urgent acuity level.

10. Nor can I find that "standing orders" are policies. A standing order cannot have the force of a policy subjecting a hospital to a fine when it is voluntary.

11. Next, the Government argues that Sibley Hospital violated a policy by not reassessing A.L. soon enough after her blood pressure fell at midnight. The policy at issue in this instance requires that a patient be monitored every twelve hours and when the condition changes. The physician order in place was for vital signs to be taken every eight hours. Sibley policies do not specify what decrease in blood pressure is necessary to trigger reassessment, or how frequently that reassessment should be. Nevertheless, the Government argues that the midnight decline in blood pressure was enough to trigger more frequent monitoring. In fact, a nurse used professional judgment when taking Patient's blood pressure four hours earlier than ordered, at 4:00 a.m., when the nurse observed a dramatic change. Therefore, a violation of policy for monitoring after midnight has not been proven.

B. Resultant Harm

12. Even if departures from hospital policy were proven, Respondent argues that the Government has not proven its case because it has not proven proximate cause. See, e.g. *Meek v. Shepherd*, 484 A. 2d 579 (D.C. 1984).

13. The Government urges this administrative court to reject the standard Respondent proposes and define "demonstrable harm" as having common meaning, a meaning distinguishable from "the rigorous scrutiny of experts that trigger malpractice defenses." Government's Response to Respondent's Motion to Dismiss at 3.

14. A common meaning of "result" is "to proceed or arise as a consequence, effect or conclusion."[3] Effect follows cause. Therefore, for Respondent to be liable for the fine set forth in D.C. Official Code § 44-509(f)(1), it must be proven that the violation of policy caused demonstrable harm. "Correlation and causation are not synonymous." *Lasley v. Georgetown University*, 688 A.2d 1381, 1387 (D.C. 1997). A mere temporal relationship does not suffice. *See Id.*

15. The Government's expert testimony comes from two professional nurses who opined that Sibley violated its own policies by incorrectly classifying Patient as nonurgent instead of urgent and by not monitoring her frequently enough.

16. A. L.. was seen by a physician within 30 minutes of her arrival in the ED and vital signs were not of concern. There is no evidence to prove that a classification of "nonurgent" resulted in harm to A.L. In fact, her blood pressure was stable at the

[3] Merriam-Webster Online, http://www.webster.com/dictionary/resulted (last visited Jan. 3, 2008).

time she was admitted to the hospital and her condition was characterized as good. The Government has not shown demonstrable harm from the triage category.

17. Whether demonstrable harm resulted from a failure to monitor A.L's condition more frequently is also an issue. No change or harm has been shown to have occurred before midnight, therefore, this analysis concentrates on the time from midnight forward. At midnight, A.L.'s blood pressure was 97/53, 10% lower than it had been four hours earlier when it was 108/61. At midnight, the physician order in place called for vital signs, including a blood pressure reading, every eight hours.

18. Ms. Wilson noted that A. T. had symptoms of shock. However, there is no evidence on how a different triage category or more frequent monitoring would have prevented those symptoms. The nurse experts were not offered as experts in the fields of medicine or pathophysiology, necessary qualifications for an opinion on resultant harm in the context of monitoring, shock, perforated bowel and ultimate death. *See e.g. Haidak v. Corso*, 841 A.2d 316, 322-23 (D.C. 2004) (expert testimony of anesthesiologist properly excluded because expert never treated condition at issue); *Structural Pres. Sys. V. Petty*, 927 A. 2d 1069, 1080 (D.C. 2007) (testimony regarding physical therapy was beyond the expertise of a chiropractor).

19. The Government intimates that more frequent monitoring would have led to earlier intervention that in turn would have prevented shock, led to earlier surgery and prevented A. L's death. The record lacks the evidence to support such a conclusion. Therefore, demonstrable harm has not been proven.

IV. ORDER

Therefore, it is this 28th day of February 2008:

ORDERED, that Respondent's Motion for Judgment as a matter of law is **GRANTED**; it is further

ORDERED, that the Notice of Violation **is DISMISSED WITH PREJUDICE;** it is further

ORDERED, that the appeal rights of any party aggrieved by this Order are stated below.

February 28, 2008

_____/s/_____
Margaret A. Mangan
Administrative Law Judge